ACTING ASSISTANT SECRETARY OF THE ARMY
(MANPOWER AND RESERVE AFFAIRS)

HOUSE GOVERNMENT REFORM COMMITTEE HEARING

ON

"WOUNDED ARMY GUARD AND RESERVE FORCES: INCREASING THE CAPACITY TO CARE"

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STATEMENT BY
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Chairman Davis and members of the committee, thank you for inviting us to discuss the Medical Holdover (MHO) program. As you know, we continue to face many challenges, to include the Global War on Terrorism (GWOT) and the continuing operations to rebuild Iraq. In all of this, the Army is absolutely committed to taking care of its Soldiers and families and providing them the best possible health care. This is true regardless whether a Soldier is a member of the Active Army or Reserve Components, and regardless of the nature of the Soldier's injury or illness, whether it occurred in combat or training.

The Army continues to intensively manage the health care and disposition of Reserve Component (RC) Soldiers in an MHO status. As a review, MHO Soldiers are mobilized RC Soldiers, pre-deployment or post-deployment, no longer located with his/her unit, in need of definitive health care based on medical conditions identified while in support of the GWOT. Soldiers whose mobilization orders have expired and were placed on Active Duty Medical Extension (ADME) are included in this population.

The Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA (M&RA)) provides oversight over MHO operations and, along with Forces Command (FORSCOM), the Executive Agent for the program, are engaged in monitoring the effectiveness of the MHO program. Under the auspices of ASA (M&RA), a system analysis and review team (SAR) has visited and assessed the operations of every installation that has MHO Soldiers.

Execution of the MHO program is comprised of three major functional areas: outpatient medical care, command and control, and administration. Multiple Army organizations are

involved in executing these functional areas. Leaders from these organizations are here to speak in more detail on their areas of responsibility.

We all remember what happened at Fort Stewart and Fort Knox. The large number of MHO Soldiers on those installations exceeded the capacity of the military infrastructure to adequately house them and provide expeditious medical care management. Upon review, we realized this problem was not confined to just these installations and, thus, we immediately embarked on a series of actions to address this unacceptable situation. Let me quickly review what occurred:

- In November 2003 we modified appropriate mobilization orders to ensure the Soldiers identified during the first 25 days of mobilization with pre-existing medical conditions that made them non-deployable were released from active duty and returned to their civilian status.
- The Army instituted new and specified standards ensuring more rapid delivery of care in key areas such as screening, specialty appointments, surgery, etc. For example, the Army Surgeon General specified 72 hours for initial specialty consultation, one week for magnetic resonance imaging and other diagnostic studies, two weeks for surgery, and 30 days for Medical Evaluation Board (MEB) processing. We also provided more military personnel to provide command and control to ensure that Soldiers were treated expeditiously and we assigned at least one Case Manager for every 50 MHO Soldiers and at least one Physical Evaluation Board Liaison Officer (PEBLO) for every 65 active Medical Evaluation Board (MEB) cases.

- Increased the medical infrastructure—hired/mobilized nearly 800 additional physicians, nurses, clerks and case managers—to provide more responsive, high quality treatment at Medical Treatment Facilities (MTF).
- Upgraded the billets in which MHO Soldiers are housed to ensure the facilities met Soldiers' medical needs and were as good as or better than the billeting for Active Army Soldiers on the same installations (Fort Campbell has moved Soldiers off-post into hotels until adequate housing can be provided).
- Established a dedicated chain-of-command at each installation to monitor MHO Soldiers' medical care progress and provide necessary overall support while they are in a MHO status.
- Established the Medical Retention Processing (MRP) program, providing the means to more efficiently transition MHO soldiers from mobilization status to medical Extension. The MRP program has been instrumental in eliminating pay and order issues previously experienced by some MHO Soldiers under GWOT ADME. We are currently in the process of converting all GWOT ADME Soldiers to the MRP program. This should be completed by the beginning of next month.

A frequent misconception with the MHO program is that we are retaining the injured or ill soldiers on Active Duty against their will and on installations far from their homes and families. This is not the case. Medical Retention Processing (MRP) and its predecessor for GWOT ADME, are voluntary programs. Once our military medical authority determines that the Soldier cannot be expected to heal within 60 days, the Soldier is provided the choice to be released from Active Duty and receive his line-of-duty medical care locally from

Tricare providers in his home area or elect to remain on Active Duty in a voluntary status specifically to have his medical issues addressed. If the Soldier elects to remain on Active Duty, the Soldier will continue to receive full pay and allowances while he moves through the healing process. Furthermore, if the Soldier elects to remain on Active Duty, the Army will then assign the Soldier to a duty location where the Army can best support the necessary medical care appropriate for the Soldier. Where practical and supportable, the Army tries to place the Soldier at an installation near his home, however, availability of medical and support assets must ultimately determine the appropriate location.

On 1 November 2003, a total of 4452 RC GWOT Soldiers were at Army installations in an MHO status and 400 on GWOT ADME. As of 1 February 2005, 351 of the 1 November 2003 population remain in a MHO or ADME status for a total of 95% processed. These remaining 351 Soldiers are either undergoing extensive medical treatment or moving through the medical evaluation board/physical evaluation board (MEB/PEB) processes. Though substantial numbers of Soldiers have completed the MHO process (15,338), a growing number of Soldiers continue entering the system as deployments and redeployments continue.

Rotation of forces for Operation Iraqi Freedom/Operation Enduring Freedom is expected to significantly increase the total MHO population in the coming months. This surge could exceed Medical Command's (MEDCOM) medical support capacity by the 3rd Quarter 2005. One of the key initiatives we are executing to increase our MHO medical support capacity and expand the Army's commitment to taking care of MHO Soldiers is the Community Based Health Care Initiative (CBHCI). Today, I would like to provide details on this highly successful program.

The CBHCI began as a way of providing high quality care to Army Guard and Reserve Soldiers nearer to their homes while maintaining administrative control of MHO Soldiers and relieving pressure on Army medical facilities at Power Projection Platforms—installations with Active Army tenant units that also function as mobilization sites for Army Guard and Reserve Soldiers. The CBHCI has proved itself as a means of providing a way for the Army to: 1) meet its obligation to care for Reserve Soldiers who require protracted treatment to attain full recovery from their injuries/illnesses, 2) exercise compassion for Reserve Soldiers who endured separation from their families, and 3) leverage sister Services, Veterans' Administration, and civilian health care assets. Key highlights of this initiative:

- We began with five Community Based Health Care Organizations (CBHCO) in a pilot program to test if they would be effective in accomplishing their intended missions. Upon evaluation, CBHCOs proved to be a viable and effective means to improve our health care apparatus—providing first rate care for MHO Soldiers and expanding billeting capacities at installation health care facilities.
- The initial five CBHCOs are located in Plant City, Florida; Little Rock, Arkansas; Sacramento, California; Boston, Massachusetts; and Madison, Wisconsin. They service associated geographical regions, in an area totaling 23 States. For example, the Wisconsin CBHCO covers the states of Wisconsin, Iowa, Illinois, Indiana, Michigan, and Minnesota.
- CBHCOs are manned by mobilized Reserve Component Soldiers and are supported by the First and Fifth Armies which bear responsibility for training and mobilizing the Guard and Reserve nationwide.

- Of the 5112 total MHO Soldiers, the five CBHCOs currently are managing 1480 MHO Soldiers between them. That's 29% of the total MHO population. The success of the program has led to its expansion. Three additional locations being activated are Alabama (Birmingham) and Virginia (Virginia Beach) (both become operational this month and Utah (Salt Lake City) (will be operational in a few weeks). Concurrently, three additional CBHCO-hybrid (smaller version of the CBHCO) sites are being planned for Alaska, Hawaii, and Puerto Rico. When fully operational, complete regional coverage of the 50 states and four territories will be provided by these 11 organizations.
- Fully manned, each individual CBHCO is designed to support a total sustained capacity of 500 Soldiers. The CBHO program currently has a total sustained capacity of 2500 Soldiers across five CBHCOs. When the three additional sites are activated, the combined CBHCO program would support a total capacity of 4000 Soldiers. With the addition of the three smaller planned CBHCO-hybrid sites, 100 Soldiers can be accommodated at each of these locations, thereby increasing the total MHO Soldier capacity to 4300.
- The bottom line is that the CBHCO program is a success story for Soldiers and their families and the Army. CBHCOs have evolved from a reactive response to substandard situations at a few posts to an innovative program designed to manage the prolonged health care treatment needed by some Reserve Component Soldiers in order for them to fully recover…CBHCOs ensure the same standard of care we require for all Soldiers is met while providing a means of accounting for Soldiers and expanding our billeting capacity Army-wide…and CBHCOs alleviate the stress

caused by the separation of Soldiers from their families by moving MHO Soldiers closer to home.

We will continue to work closely with FORSCOM, the Installation Management Agency, the Office of the Surgeon General, Headquarters Department of the Army, G-1, and various other Army organizations and staffs to identify and remove barriers to expeditious evaluation and treatment, and to assist in the prompt return to duty or release from active duty those Soldiers serving in our Reserve Components. I thank the committee for its continued commitment and support to quality care for our Soldiers and to the readiness of our forces and for giving us the opportunity to address the committee about our Medical Holdover program.